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# PROGNOSIS FOR SYNERGY BETWEEN ACCOUNTABLE CARE ORGANIZATIONS AND BUNDLED PAYMENTS IN MEDICARE

*Peter Fise*\*

## I INTRODUCTION

Due to the significant political and external pressures to better control United States federal spending over the near and long-term, efforts to generate savings in the Medicare program have become central to budget policymakers' concerns. Recognizing these concerns, the 2010 health care reform law—the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and referred to collectively as the Affordable Care Act (“ACA”)—required that the Centers for Medicare and Medicaid Services (“CMS”) establish a Medicare Shared Savings Program (“MSSP”) for Accountable Care Organizations (“ACOs”).<sup>1</sup> The ACA also required CMS to develop a National Pilot Program on Payment Bundling<sup>2</sup> within the Medicare system. Both programs are intended to change the way health care is delivered to Medicare beneficiaries by incentivizing coordination and integration of care, which ultimately produces savings for the Medicare program.<sup>3</sup> In implementing these new payment models, it will be critical for CMS to structure the programs in a manner that allows the models to work

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3022, 10,307, 124 Stat. 119, 395, 940 (2010) (amending title XVIII of the Social Security Act, 42 U.S.C. § 1395 (2006), by adding § 1899, “Shared Savings Program”) [hereinafter PPACA].

2. *Id.* §§ 3023, 10,308 (amending title XVIII of the Social Security Act by adding § 1866D, “National Pilot Program on Payment Bundling”).

3. Social Security Act § 1899(a)(1); *see also* Social Security Act § 1866D(a)(1).

in tandem, layering bundled payments within the context of the MSSP to ensure that providers are given incentives to coordinate care and hold down costs at both the global per-beneficiary level and the per-episode of care level. Furthermore, in allowing for contemporaneous participation in both the ACO model and bundled payments, CMS will need to allocate payment incentives from each program in a way that avoids duplicative shared savings payments in order to maximize the promise of these provider payment reforms.

#### *A. Statutory Framework for ACOs*

Section 3022 of the ACA established the MSSP for ACOs<sup>4</sup> and includes various requirements that must be satisfied by a provider or group of providers seeking to enroll as an ACO in the MSSP. Under Congress' vision for ACOs, the program will encourage providers to establish new health care entities that coordinate care for an assigned group of at least 5,000 Medicare beneficiaries,<sup>5</sup> in a manner that reduces costs through the elimination of duplicative services and the removal of inefficiencies associated with fragmented care across settings.<sup>6</sup> To incentivize the formation of such entities, the program allows ACOs to share with Medicare a portion of the savings that result through the reduction of expenditures per beneficiary, as compared to pre-determined spending benchmarks.<sup>7</sup>

Importantly, the Social Security Act section 1899(i), added by ACA section 3022, allows CMS to pursue other payment options deemed appropriate for ACOs.<sup>8</sup> Under this statutory authority, CMS proposed and

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4. See PPACA § 3022.

5. Social Security Act § 1899(b)(2)(D) (requiring that “at a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program”).

6. Social Security Act § 1899(a)(1).

7. Social Security Act § 1899(d)(1)(B)(i) (authorizing payments to ACOs for shared savings “if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark”).

8. Social Security Act § 1899(i)(2) (authorizing the Secretary of the Department of Health and Human Services to “use any of the payment models . . . for making payments under the program rather than the payment model described in subsection (d)” —which is the traditional one-sided model shared savings model—and stipulating that a partial

finalized both a one-sided risk model and a two-sided risk model.<sup>9</sup> Under the one-sided model, ACOs are eligible to share in the savings generated through care coordination, but are not financially responsible for losses which result when the cost of care exceeds pre-determined benchmarks.<sup>10</sup> Under the two-sided model, ACOs must assume financial risk for a percentage of the losses that result when the expenditures for a given beneficiary exceed the benchmark level.<sup>11</sup> The two-sided model for ACO shared savings participation is designed to ensure that individual providers within the ACO have appropriate incentives to limit excess use and counterbalance the continuation of fee-for-service (“FFS”) physician reimbursement through the Medicare Physician Fee Schedule (“PFS”), which incentivizes greater utilization of health care services.<sup>12</sup>

The concern, raised by the Medicare Payment Advisory Commission (“MedPAC”), is that under a one-sided model approach to ACO shared savings—in which the ACO assumes no risk of losses—individual

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capitation model is one “in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B . . . such as at risk for some or all physicians’ services or all items and services under part B” and clarifying that “[t]he Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary”).

9. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,977-67985 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425) (amending 42 C.F.R. pt. 425 by adding § 425.200(b)(2) to establish that “for 2013 and all subsequent years, the term of the agreement is 3 years” and by adding § 425.600 to require that during the first 3-year agreement period, MSSP participating ACOs must elect to operate under either “Track 1,” which operates under a “one-sided model” that allows ACOs to share in savings generated without assuming risk for losses incurred when per-beneficiary expenditure levels exceed per-beneficiary benchmarks; or alternatively operate under “Track 2,” which requires the ACO to assume downside risk, but also offers ACOs a greater percentage share of savings generated. New section 425.600(c) requires that in all subsequent three-year agreement periods—following the first 3-year agreement period—an ACO must elect to operate under “Track 2.”).

10. *Id.* at 67,975.

11. *Id.*

12. *Id.* at 67,908; *see also* MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2011), [http://medpac.gov/documents/Mar11\\_EntireReport.pdf](http://medpac.gov/documents/Mar11_EntireReport.pdf).

physicians within the ACO would find that their potential individual benefit received through the ACO's distribution of shared savings (generated through containment of service volume growth) could easily be outweighed by the financial incentive to continue to drive volume growth (because physicians participating in ACOs are still reimbursed for physician services under the Medicare PFS).<sup>13</sup> While the final regulations establishing the MSSP allow for ACOs to elect to operate under either the one-sided model or the two-sided model during the entirety of the initial 3-year agreement period, CMS used its authority (under Social Security Act section 1899(i)) to require that ACOs seeking to engage in subsequent 3-year agreements, after the initial 3-year agreement, must elect to operate under the two-sided model.<sup>14</sup>

### B. *Statutory Framework for Bundled Payments*

Section 3023 of the ACA requires the establishment of a National Pilot Program on Payment Bundling,<sup>15</sup> which will test a new payment system within Medicare FFS that provides consolidated payment for a single "episode of care." The bundled payment will be calculated by integrating Medicare payments for hospital inpatient and outpatient services, physician services provided both inside and outside of the hospital setting, emergency room services, and post-acute care services.<sup>16</sup> While the bundled payment

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13. MEDICARE PAYMENT ADVISORY COMM'N, COMMENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) REQUEST FOR INFORMATION REGARDING ACCOUNTABLE CARE ORGANIZATIONS AND THE MEDICARE SHARED SAVINGS PROGRAM 3 (2010), [http://medpac.gov/documents/11222010\\_ACO\\_COMMENT\\_MedPAC.pdf](http://medpac.gov/documents/11222010_ACO_COMMENT_MedPAC.pdf) (noting that "in a bonus-only model there is some incentive to control spending for services from providers outside the ACO. But that incentive is weaker for services the ACO provides directly because the ACO still receives FFS payments for those services and those payments are certain."); *see also* Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,904 (suggesting that while a "one-sided model" ACO payment structure "may provide incentive for participants to improve quality, it may not be enough of an incentive for participants to improve the efficiency and cost of health care delivery").

14. 42 C.F.R. § 425.600(a)-(b) (2012).

15. *See* PPACA, Pub. L. No. 111-148, § 3023, 124 Stat. 119, 399 (2010).

16. Social Security Act § 1860D(a)(2)(C), 42 U.S.C. § 1395 (2006) (establishing that "applicable services" covered for single unified payment under an "episode of care" in the National Pilot Program on Payment Bundling consist of "(i) Acute care inpatient services[;] (ii) Physicians' services delivered in and outside of an acute care hospital setting[;] (iii) Outpatient hospital services, including emergency department services[;]

model allows providers to retain any amount by which the actual cost of care was below the bundled payment for the episode, it simultaneously requires providers to assume financial risk for any amount by which the actual cost of care exceeds the bundled payment amount for the episode.<sup>17</sup>

Under the ACA, the National Pilot must be established by January 1, 2013, and will operate for five years.<sup>18</sup> The National Pilot will test this payment model on up to 10 conditions selected and deemed appropriate by CMS.<sup>19</sup> Importantly, Social Security Act section 1866D(c)(1)(B), added by ACA section 3023, authorizes CMS to expand the scope and duration of the program at any point after 2016—potentially incorporating bundled payments across the Medicare FFS program—so long as the National Pilot demonstrates the capacity to generate Medicare savings while ensuring high quality care.<sup>20</sup>

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(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital[; and] (v) Other services the Secretary determines appropriate.”).

17. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: REFORMING THE DELIVERY SYSTEM 83-101 (2008), [http://medpac.gov/documents/Jun08\\_EntireReport.pdf](http://medpac.gov/documents/Jun08_EntireReport.pdf) [hereinafter REFORMING THE DELIVERY SYSTEM].

18. Social Security Act § 1866D(a)(3); *see also* Social Security Act § 1866D(c)(1)(A).

19. Social Security Act § 1866D(a)(2)(D) (establishing that the term applicable condition “means 1 or more of 10 conditions selected by the Secretary” and requiring that “in selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors: (i) Whether the conditions selected include a mix of chronic and acute conditions[;] (ii) Whether the conditions selected include a mix of surgical and medical conditions[;] (iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures . . . [;] (iv) Whether a condition has significant variation in—(I) the number of readmissions; and (II) the amount of expenditures for post-acute care spending . . . [;] (v) Whether a condition is high-volume and has high post-acute care expenditures . . . [; and] (vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns”).

20. Social Security Act § 1866D(c)(1)(B) (establishing that “The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—(i) the Secretary determines that such expansion is expected to—(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or (II) improve the quality of care and

### C. Rulemaking and Implementation of Each Model

In November 2011, CMS published a final rule to establish the MSSP for ACOs.<sup>21</sup> At the same time, the CMS Center for Medicare and Medicaid Innovation (“CMMI”) separately launched the Pioneer ACO Model.<sup>22</sup> In addition to providing two tracks for ACOs to choose to operate under, the MSSP final rule provides the framework for ACO shared savings payment determinations.<sup>23</sup> ACOs must report on their performance of providing quality care based on 33 quality metrics established by CMS.<sup>24</sup> The ACO’s aggregate quality performance score then determines the ACO’s “sharing rate,” or the percentage of shared savings that the ACO will be allowed to retain.<sup>25</sup> ACOs achieving the highest quality scores will receive the highest sharing rates.<sup>26</sup> Under the final rule, the maximum sharing rate for track one

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reduce spending; (ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and (iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals”).

21. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,802-990 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

22. Medicare Program; Pioneer Accountable Care Organization Model: Request for Applications, 76 Fed. Reg. 29,244, 29,249-50 (May 20, 2011) (announcing the request for applications for the Pioneer ACO program); *see generally* CTR. FOR MEDICARE AND MEDICAID INNOVATION (CMMI), CTRS. FOR MEDICARE AND MEDICAID SERVS. (CMS), PIONEER ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL REQUEST FOR APPLICATION (2011), <http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Request-For-Applications-document.pdf>.

23. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,802-990.

24. *Id.* at 67,889-90 (amending 42 C.F.R. § 425.500 by adding § 425.500(d) to establish quality metrics across four measure domains: “(i) patient/care giver experience; (ii) care coordination; (iii) preventative health; and (iv) at-risk population”).

25. *Id.* at 67,986-87.

26. *Id.* at 67,984 (amending 42 C.F.R. pt. 425 by adding § 425.502(e) to provide that: “(1) CMS scores individual measures and determines the corresponding number of points that may be earned based on an ACO’s performance. (2) CMS adds the points earned for the individual measures within the domain and divides by the total points available for the domain to determine the domain score. (3) Domains are weighted

ACOs is set at 50%—meaning that ACOs in this track may share in a maximum of 50% of the savings generated relative to the per-beneficiary benchmarks.<sup>27</sup> Meanwhile, the maximum sharing rate for track two ACOs is set at 60%—meaning that they share in a maximum of 60% of the savings.<sup>28</sup>

For track two ACOs, the ACO’s “shared loss rate”—or the percentage of actual costs in excess of the per-beneficiary benchmark that must be absorbed by the ACO—is equal to one minus the ACO’s shared savings rate.<sup>29</sup> For example, if a track two ACO’s sharing rate is 45%, then its shared loss rate would be 55%. This would mean that the ACO would be financially responsible for 55% of the excess costs above the per-beneficiary benchmark, with the Medicare program becoming financially responsible for the remainder. The final rule created a maximum shared loss rate of 60%.<sup>30</sup>

Additionally, the final rule establishes minimum levels of savings, relative to the benchmarks, that must be achieved before ACOs may share in savings. This is referred to as the minimum savings rate or MSR.<sup>31</sup> For track one ACOs, the MSR ranges from 2% to 3.9%, depending on the size of the ACO,<sup>32</sup> while track two ACOs have a uniform 2% MSR regardless of

equally and scores averaged to determine the ACO’s overall performance score and sharing rate.”).

27. *Id.* at 67,986 (amending 42 C.F.R. pt. 425 by adding § 425.604(d) to establish that an ACO participating in the one-sided model may receive “a shared savings payment of up to 50 percent of all savings under the updated benchmark”).

28. *Id.* at 67,987 (amending 42 C.F.R. pt. 425 by adding § 425.606(d) to establish that an ACO participating in the two-sided model may receive “shared savings payments of up to 60 percent of all the savings under the updated benchmark”).

29. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,987 (amending 42 C.F.R. pt. 425 by adding § 425.606(f) to establish that when “an ACO . . . is required to share losses with the Medicare program for expenditures over the updated benchmark, the of amount of shared losses is determined based on the inverse of its final sharing rate . . . (that is, 1 minus the final shared savings rate)”).

30. *Id.*

31. *Id.* at 67,986 (amending 42 C.F.R. § 425 by adding § 425.604(b) to require that “CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO.to establish the MSR for an ACO participating under the one-sided model”).

32. *Id.*



size.<sup>33</sup> So, for example, if an ACO has an MSR of 2.5%, the total expenditures for beneficiaries assigned to that ACO must be at least 2.5% below the pre-determined benchmark expenditure level in order for the ACO to share in any savings. The application of the MSR is designed to ensure that ACOs are not awarded shared savings for savings that are generated through random variation in costs, rather than actual care coordination.<sup>34</sup> Similarly, the final rule limits maximum shared savings to a percentage of the benchmark.<sup>35</sup> Under this structure, track one ACOs' shared savings are capped at 10% of the benchmark,<sup>36</sup> while track two ACOs' shared savings are capped at 15% of the benchmark.<sup>37</sup> Finally, track two ACOs' shared losses are also capped at certain percentages of the benchmark under a similar structure.<sup>38</sup> Essentially, track two ACOs will not be financially responsible for losses in excess of the shared loss cap, which is applied at 5%, 7.5%, and 10% for years one through three, respectively, of the first MSSP agreement period.<sup>39</sup>

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33. *Id.* at 67,987 (amending 42 C.F.R. pt. 425 by adding § 425.606(b)(1) to require that “[t]o qualify for shared savings under the two-sided model, an ACO’s average per capita Medicare expenditures for the performance year must be below its updated benchmark costs for the year by at least 2 percent.”).

34. *Id.* at 67,927.

35. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,934.

36. *Id.* at 67,986 (amending 42 C.F.R. pt. 425 to add § 425.604(e)(2) to require that “the amount of shared savings an eligible ACO receives under the one-sided model may not exceed 10 percent of its updated benchmark.”).

37. *Id.* at 67,987 (amending 42 C.F.R. pt. 425 to add § 425.606(e)(2) to require that “the amount of shared savings an eligible ACO receives under the two-sided model may not exceed 15 percent of its updated benchmark.”).

38. *Id.* at 67,937.

39. *Id.* at 67,987 (amending 42 C.F.R. pt. 425 to add § 425.606(g) to establish that “the amount of shared losses for which an eligible ACO is liable may not exceed the following percentages of its updated benchmark . . . (1) 5 percent in the first performance year in a two-sided model under the Shared Savings Program; (2) 7.5 percent in the second performance year; (3) 10 percent in the third and any subsequent performance year”).

In establishing the Pioneer ACO Model, CMMI utilized its authority under Social Security Act section 1115A, which was added by section 3021 of the ACA,<sup>40</sup> to pilot and test an alternative Medicare payment system in which Pioneer ACOs enrolling in the new CMMI program are eligible for substantially higher percentage shares of savings generated, in exchange for assuming more downside risk and agreeing to move towards a capitated payment model.<sup>41</sup> Under this model participating ACOs would become more fully responsible for expenditures above the predetermined beneficiary benchmarks over the course of a 5-year agreement period. Additionally, ACOs would be entitled to up to 70% of all of the Medicare savings generated by holding costs below the benchmarks.<sup>42</sup> Pioneer ACO sharing rates would be determined under the same quality performance rubric that govern the MSSP sharing rates,<sup>43</sup> but in addition to being subject to higher sharing rates and shared loss rates (relative to the MSSP levels), they would also be subject to higher sharing caps and shared loss caps.<sup>44</sup>

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40. PPACA, Pub. L. No. 111-148, § 3021(a)(1), 124 Stat. 119, 389 (2010) (amending the Social Security Act by adding § 1115A, 42 U.S.C. § 1315a (2006), to establish within CMS the Center for Medicare and Medicaid Innovation to “test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles.”).

41. CTR. FOR MEDICARE AND MEDICAID INNOVATION (CMMI), CTRS. FOR MEDICARE AND MEDICAID SERVS. (CMS), *supra* note 22, at 8. (stating that CMMI is “interested in testing alternative payment models that: (1) include escalating levels of financial accountability through successive periods during the Participation Agreement; (2) provide a transition from fee-for-service to population-based payment by the third performance period; and (3) generate Medicare savings”).

42. *Id.*

43. *Id.* at 17 (explaining that “performance measures will mirror those in the final regulations for the Shared Savings Program” and those quality scores for Pioneer ACOs will determine the ACO’s sharing rate for the purposes of retention of shared savings).

44. *Id.* at 8 (clarifying that in performance year one, Pioneer ACOs will be eligible to receive up to 60 percent of shared savings and will be accountable for up to 60 percent of shared losses, and in performance year two, Pioneer ACOs will be eligible for up to 70 percent of shared savings and will be accountable for up to 70 percent of shared losses); *see also id.* at 17 (noting that quality incentive calculations will be “updated to be consistent with final regulations for the Shared Saving Program,” which indicates that CMMI may increase the maximum sharing rates, sharing caps, and shared loss caps to reflect increases in each under the MSSP final rule—in a manner that ensures that

Under the Pioneer ACO Program's Core Payment Arrangement, in performance year three, Pioneer ACOs that generate a minimum average annual savings over performance years one and two will "transition to population-based payment in period three," with population-based payment defined as a "per-beneficiary per month payment amount intended to replace a significant portion of the ACO's FFS with a prospective payment."<sup>45</sup> In the population-based payment structure, Pioneer ACOs will continue to receive Medicare FFS payment "at 50 percent of fee-for-service payment rates on submitted claims," and will receive monthly population-based payments that will equal "the remainder of the ACO's projected FFS revenue for its aligned Medicare patients."<sup>46</sup> For example, if an aligned beneficiary for a Pioneer ACO had projected monthly Medicare FFS costs of \$750 and actually incurred \$600 in FFS claims, the ACO would receive 50% of the FFS payment rate on the actual FFS claims—or \$300—and would receive \$375 in a monthly population-based payment.<sup>47</sup> However, if the same beneficiary incurred \$900 in actual FFS claims, the ACO would receive \$450 (50% of \$900) in Medicare FFS payments and a \$375 monthly population-based payment.<sup>48</sup> Under this structure, Pioneer ACOs generate positive revenue margins—relative to traditional Medicare FFS payments—when the beneficiary's costs are held below projected levels; but they are financially at risk in instances where the beneficiary's costs exceed the Pioneer ACO's projected level.

The Pioneer ACO Program was designed to act as an alternative to the MSSP<sup>49</sup> for experienced clinically-integrated health systems that assume

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Pioneer ACO maximum sharing rates, sharing caps, and shared loss caps are greater than those included under the MSSP, as originally intended).

45. *Id.* (clarifying that the minimum average annual savings amount for qualification to transition to population-based payment "will be no greater than 5% (for ACOs in states with the lowest historical Medicare expenditure levels) and no less than 1% (for ACOs in states with the highest historical Medicare expenditure levels), and will vary inversely with the relative Medicare expenditure level in the state where the ACO is located").

46. CTR. FOR MEDICARE AND MEDICAID INNOVATION (CMMI), CTRS. FOR MEDICARE AND MEDICAID SERVS. (CMS), *supra* note 22, at 9.

47. *Id.* at 35-36.

48. *Id.*

49. CTRS. FOR MEDICARE AND MEDICAID SERVS. (CMS), PIONEER ACO MODEL: GENERAL FACT SHEET 1 (2011), <http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>.

greater levels of downside risk and financial responsibility for beneficiary costs.<sup>50</sup> Importantly, Social Security Act section 1115A(c) grants CMS the authority to expand payment models tested at CMMI to the entire Medicare program, provided that the Secretary of HHS (in consultation with the CMS Chief Actuary) determines that the model will reduce Medicare spending without reducing beneficiaries' access to benefits and services, or decreasing quality of care.<sup>51</sup> Given this sweeping authority, it is conceivable that the Pioneer ACO Program, if successful, could be expanded to operate as a permanent alternative option for all potential ACOs, in addition to the MSSP's track one and track two options.

In August 2011, CMMI issued a request for applications for its Bundled Payments for Care Improvement Initiative,<sup>52</sup> which, while not explicitly a part of the National Pilot Program on Payment Bundling, serves as a useful insight into the potential constructs of the National Pilot. The Initiative is composed of four separate payment models in which providers may enroll.<sup>53</sup> Due to this Comment's focus on aligning hospital payments and physician payments in Medicare, this discussion will focus on Models One and Four, which address hospital inpatient stays and physician services associated with inpatient stays, while Models Two and Three, which focus on post-acute

50. *Id.* at 2.

51. Social Security Act § 1115(c), 42 U.S.C. § 1315 (2006) (authorizing the Secretary of HHS to, "through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested . . . if (1) the Secretary determines that such expansion is expected to—(A) reduce spending under applicable title without reducing the quality of care; or (B) improve the quality of patient care without increasing spending; (2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and (3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.").

52. Bundled Payments for Care Improvement Initiative: Request for Application, 76 Fed. Reg. 53,137, 53,137-54,138 (Aug. 25, 2011) (announcing the request for applications for the Bundled Payments for Care Improvement Initiative); *see generally* CTR. FOR MEDICARE AND MEDICAID INNOVATION (CMMI), CTRS. FOR MEDICARE AND MEDICAID SERVS. (CMS), BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE REQUEST FOR APPLICATION (2011), <http://innovations.cms.gov/Files/x/Bundled-Payments-for-Care-Improvement-Request-for-Applications.pdf> [hereinafter BUNDLED PAYMENTS FOR CARE].

53. BUNDLED PAYMENTS FOR CARE, *supra* note 52.

care services rather than physician services, will not be addressed. Each model requires providers to negotiate and enter into agreements with CMMI that allow for discounted target payments of different episodes of care.<sup>54</sup> To the extent that clinically-integrated providers are able to hold down costs below the targets, participating providers will be allowed to retain the surplus generated.<sup>55</sup>

Under the Bundled Payments for Care Improvement Initiative's "Model One," an episode of care is defined as an "acute inpatient hospital stay for all Medicare FFS beneficiaries" admitted to an acute care inpatient hospital of a Bundled Payment participating provider, irrespective of condition or severity.<sup>56</sup> An episode includes "all Medicare Part A services furnished to included beneficiaries during the hospital stay," but excludes physician services reimbursed under Medicare Part B.<sup>57</sup> Physician services will continue to be reimbursed under the Medicare PFS, but the hospital's physicians "will be permitted to share gains"—referred to as "gainsharing" arrangements—arising from holding Medicare Part A service costs below the agreed upon, discounted Medicare Inpatient Prospective Payment System ("IPPS") payment rate for the particular condition.<sup>58</sup> By the third year of the initiative, Bundled Payment-participating providers will be expected to offer "a minimum 2% discount to Medicare on all Part A hospital inpatient payments."<sup>59</sup> By employing an allowance for gainsharing between hospitals and physicians, this Model seems to have a goal of aligning payment incentives between (1) acute care inpatient hospitals that are paid pre-set payment rates based on patient condition and severity, regardless of actual costs of treatment; and (2) hospital-based physicians that are paid on a fee-for-service basis for each service delivered.

In "Model Four," CMMI will provide a single prospective payment of a pre-determined amount for all Medicare Part A inpatient hospital services and Medicare Part B physician services "for episodes of inpatient hospitalization for [participant] selected conditions."<sup>60</sup> The duration of an

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54. *Id.* at 11.

55. *Id.* at 3.

56. *Id.* at 10.

57. *Id.*

58. *Id.* at 11.

59. BUNDLED PAYMENTS FOR CARE, *supra* note 52.

60. *Id.* at 20.

episode will consist of the three days prior to initial hospital admission through any related readmission.<sup>61</sup> Bundled Payment participants are expected to offer a single target price that “includes a single rate of discount off of the expected Medicare Part A and Part B payments for all hospital facility and [physician] professional services furnished during the hospitalization” for agreed-upon conditions that constitute episodes of care.<sup>62</sup> CMMI expects Model Four participants to offer a discount of at least 3% of estimated average combined Part A and Part B expenses for the given condition.<sup>63</sup> Establishing a capped, combined Part A and Part B payment rate for all services delivered in connection with a particular inpatient condition provides even stronger incentives for physicians to work with the hospital to eliminate unnecessary or duplicative services and constrain utilization growth rates that drive aggregate increases in Medicare expenditures.

## II. OUTLOOK OF ACOS AND BUNDLED PAYMENTS: ASSESSING ACHIEVEMENT OF PRIOR MODELS

The genesis of both models stems from recommendations offered by MedPAC, Congress’ advisory body on Medicare payment and benefit design issues. In its June 2009 Report to Congress, MedPAC recommended that the Secretary of HHS institute a shared savings program for ACOs.<sup>64</sup> In its June 2008 Report to Congress, MedPAC recommended the establishment of a voluntary bundling pilot within Medicare.<sup>65</sup> Both models have been extensively tested by both CMS and private payers. The results of these demonstration projects and private-sector payment initiatives provide case-studies that have been reviewed by CMS and others in ongoing development

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61. *Id.*

62. *Id.*

63. *Id.* at 21.

64. See generally MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM 39-56 (2009), [http://medpac.gov/documents/Jun09\\_EntireReport.pdf](http://medpac.gov/documents/Jun09_EntireReport.pdf) [hereinafter IMPROVING INCENTIVES IN THE MEDICARE PROGRAM].

65. REFORMING THE DELIVERY SYSTEM, *supra* note 17, at 85.

of both the ACO program and the bundled payment pilot required by the ACA.<sup>66</sup>

*A. Shared Savings Models in Medicare Demonstrations and in the Private Sector*

In developing a framework for the MSSP for ACOs, CMS must carefully balance the need to ensure that the MSSP generates savings for the Medicare program with the need to ensure that a sufficient number of providers form ACOs and enroll in the voluntary program.<sup>67</sup> If the ACOs' shares of savings are too limited, few provider groups will be incentivized to participate. On the other hand, if shared savings are too generous, the Medicare program will not accrue sufficient savings to make the program worthwhile. Several case studies of shared savings successes and pitfalls exist, some of which will be reviewed here.

Since 2003, the Medicare Physician Group Practice ("PGP") Demonstration has tested the efficacy of allowing large, integrated physician group practices to share in Medicare savings produced from care coordination in a manner similar to the ACO design.<sup>68</sup> The Medicare PGP

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66. HARRIET L. KOMISAR ET AL., CTR. FOR AM. PROGRESS, "BUNDLING" PAYMENT FOR EPISODES OF HOSPITAL CARE 7 (2011), [http://www.americanprogress.org/issues/2011/07/pdf/medicare\\_bundling.pdf](http://www.americanprogress.org/issues/2011/07/pdf/medicare_bundling.pdf) (noting that the Medicare Participating Heart Bypass Center Demonstration, the Medicare Acute Care Episode Demonstration, the PROMETHEUS Payment Model, and Geisinger Health System's ProvenCare program all provide valuable instances of "previous experience with bundled payments for hospital episodes"); *see also* IMPROVING INCENTIVES IN THE MEDICARE PROGRAM, *supra* note 64, at 40 (noting that "the current [Medicare] Physician Group Practice (PGP) demonstration provides an example of how a bonus-only voluntary ACO design might work.").

67. Social Security Act § 1899(b), 42 U.S.C. § 1395jjj(b) (2006) (establishing the criteria for groups of providers that are eligible to enter into 3-year ACO agreements with the Secretary).

68. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, § 412, 114 Stat. 2763 (2000) (requiring the Secretary of Health and Human Services to conduct demonstration projects to test incentives that would be designed to encourage coordination of care furnished under Medicare Parts A and B by institutional and other providers); *see also* KATHLEEN SEBELIUS, SEC'Y OF HEALTH AND HUMAN SERVS., REPORT TO CONGRESS: PHYSICIAN GROUP PRACTICE DEMONSTRATION EVALUATION REPORT 23-24 (2009), [https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP\\_RTC\\_Sept.pdf](https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_RTC_Sept.pdf) [hereinafter PHYSICIAN GROUP PRACTICE DEMONSTRATION EVALUATION REPORT].

Demonstration offers substantially higher sharing rates than can be received by ACOs in the Medicare Shared Savings Program, as Medicare PGP Demonstration sites are entitled to retain up to 80% of Medicare savings generated relative to pre-determined expenditure targets, provided that the PGP Demonstration sites meet or exceed performance targets for quality improvement.<sup>69</sup> In 2010, the fifth year of full implementation of the demonstration, all ten Medicare PGP Demonstration sites met quality performance benchmarks on at least thirty out of thirty-two quality measures, and all PGP sites increased quality scores relative to the baseline performance year.<sup>70</sup> However, the Medicare PGP Demonstration produced only moderate savings in 2010, as only four out of ten participating PGP Demonstration sites produced savings.<sup>71</sup>

The Medicare PGP Demonstration sites are slightly larger than the projected average-size ACO (Medicare PGP sites averaging 21,940 assigned beneficiaries,<sup>72</sup> as compared to projected MSSP-participating ACOs

69. PHYSICIAN GROUP PRACTICE DEMONSTRATION EVALUATION REPORT, *supra* note 68, at 4-5 (explaining that “PGPs can receive performance payments of up to 80 percent of the Medicare expenditures that are saved in a performance year. To receive the full performance payment, PGP sites must meet or exceed performance targets established for ambulatory care quality measures.”).

70. CTRS. FOR MEDICARE AND MEDICAID SERVS. (CMS), MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION: PHYSICIAN GROUPS CONTINUE TO IMPROVE QUALITY AND GENERATE SAVINGS UNDER MEDICARE PHYSICIAN PAY-FOR-PERFORMANCE DEMONSTRATION 5-6 (2011), [https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP\\_Fact\\_Sheet.pdf](https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf) (finding that “all ten physician groups achieved benchmark performance on at least 30 of 32 measures. Seven groups . . . achieved benchmark performance on all 32 performance measures” and finding that “PGPs have increased their quality scores from baseline to performance year 5 an average of 11 percentage points on diabetes measures, 12 percentage points on heart failure measures, 6 percentage points on coronary artery measures, 9 percentage points on cancer screening measures, and 4 percentage points on hypertension measures.”).

71. *Id.* (finding that four Medicare PGP demonstration sites earned incentive payments based on the estimated savings in Medicare expenditures for the patient population they serve. The groups received performance payments totaling \$29.4 million as their share of the \$36.2 million of savings generated for the Medicare Trust Fund in performance year 5).

72. PHYSICIAN GROUP PRACTICE DEMONSTRATION EVALUATION REPORT, *supra* note 68, at 26 (indicating that total assigned beneficiaries for Medicare PGP demonstration sites ranged from 9,700 assigned beneficiaries at The Everett Clinic to 38,700 assigned beneficiaries at the Marshfield Clinic).



averaging 19,259 assigned beneficiaries<sup>73</sup>) and PGP sites are experienced forerunners in clinical integration. Therefore, the lack of consistent generation of savings amongst PGP sites is not a promising indicator of potential MSSP success. Critics of the MSSP and ACO model could argue that if large, clinically-integrated health systems and multispecialty group practices with extensive experience in capitated payment systems, such as the Medicare PGP Demonstration sites, cannot achieve Medicare savings in a shared savings model, it is unlikely that smaller, less experienced ACOs could achieve significant savings in the MSSP.

However, it is important to note that Medicare PGP Demonstration sites were not required to assume downside risk,<sup>74</sup> in the manner that all ACOs will be required to by the second three-year agreement period under the MSSP.<sup>75</sup> In many ways, this reality reflects the importance of downside risk in constraining utilization and volume growth. The requirement for ACOs to eventually enter into the two-sided model could allow the MSSP-participating providers to generate savings at a level that the Medicare PGP Demonstration sites could not. Similarly, the transition to population-based

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73. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,980 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425) (indicating that CMS's Regulatory Impact Analysis for the Medicare Shared Savings Program Final Rule projects that between "1 to 5 million Medicare beneficiaries would align with between 50 to 270 ACOs during the first four years for the program." In this paper we assume—for the purposes determining projected average ACO size—that if 1 million beneficiaries were aligned with ACOs, then the total number of enrolled ACOs would equal 50 and result in ACOs averaging 20,000 assigned beneficiaries; and also assume that if 5 million beneficiaries were aligned with ACOs, then the total number of enrolled ACOs would equal 270 and result in ACOs averaging 18,518 assigned beneficiaries. Under these assumptions, by averaging the high and low end projected assigned beneficiary levels per-ACO, we can project that the average MSSP-participating ACO would be assigned 19,259 beneficiaries.).

74. PHYSICIAN GROUP PRACTICE DEMONSTRATION EVALUATION REPORT, *supra* note 68, at 9 (explaining that "if actual expenditures fall within 98 percent to 102 percent of the target, the PGP is deemed to not have saved Medicare expenditures and is not eligible for performance payments" and "if actual expenditures exceed 102 percent of target expenditures, the PGP will received no performance payments and is considered to have achieved negative Medicare savings;" however aside from the "negative Medicare savings" classification of the PGP, there are no negative consequences, financial or otherwise, for PGPs that allow actual expenditures to exceed target expenditure levels).

75. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,985.

payments in the Pioneer ACO Program could create much stronger incentives for Pioneer ACO providers to reduce excess, unnecessary utilization. Specifically, achieving expenditure levels that are below monthly population-based payments would allow Pioneer ACOs to maintain improved profit margins.

Second, on the private payer side, the “Alternative Quality Contract” (“AQC”) payment model employed by Blue Cross/Blue Shield of Massachusetts (“BCBS”) offers a valuable example of ACOs that could develop. This model is particularly relevant in light of the fact that assumption of downside risk appears to be a key component in incentivizing the generation of savings by ACO providers within shared savings models.<sup>76</sup> The AQC model allows providers to share in savings produced when patient-specific spending baseline budgets are met and requires providers to share with BCBS in the losses resulting when the patient-specific benchmarks are exceeded.<sup>77</sup> Specifically, AQC participant provider groups are eligible for pay-for-performance bonus payments of up to 10% of the spending baseline budgets. This is analogous to sharing caps in the MSSP context.<sup>78</sup> The budget baselines are negotiated between BCBS and AQC participant groups and include all inpatient and outpatient hospital facility services, physician services, rehabilitation facility services, long-term care, and prescription drug costs.<sup>79</sup>

The AQC payment model produced average quarterly savings levels of 1.9% when compared to average spending for BCBS enrollees with similar health conditions who were not in the AQC system.<sup>80</sup> AQC groups earned an average bonus payment of 3% of the baseline budget and research suggests that total payments by BCBS to AQC groups actually increased relative to the payments the groups were projected to otherwise receive.<sup>81</sup> Additionally, researchers found that AQC savings were achieved through

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76. *Id.*

77. Michael Chernew et al., *Private Payer Innovation In Massachusetts: The Alternative Quality Contract*, 30 HEALTH AFF. 1, 51-52 (2011).

78. Zirui Song et al., *Health Care Spending and Quality in Year 1 of the Alternative Quality Contract*, 365 NEW ENG. J. MED. 909, 910 (2011).

79. *Id.*

80. *Id.* at 909.

81. *Id.* at 913, 915.

changes in referral patterns rather than through changes in utilization. This occurred particularly through shifts from more expensive outpatient care services to facilities with lower fees; lower expenditures for procedures, imaging, and testing; and reductions in spending on the highest cost enrollees.<sup>82</sup> However, AQC participant groups displayed improved quality scores in their patients relative to patients treated in non-AQC settings.<sup>83</sup>

The AQC Year One results demonstrate that blending the incentives associated with shared savings and those associated with shared losses can spur positive changes in the trajectory of health care spending. While the health care costs continued to increase in the AQC model (relative to previous years), the costs increased at a slower rate than the cost-growth rate for similarly situated populations without AQC model intervention.<sup>84</sup> This is encouraging for the MSSP, as this slowing of the cost-growth rate is the precise purpose of the Shared Savings Program. However, the rather minimal cost savings produced relative to non-AQC providers should be concerning for policymakers. The 1.9% savings generated by AQC groups falls within the range of savings that could be attributed to random variation in expenditures, for which ACOs in the MSSP would not be awarded shared savings.

The propensity of both the Medicare PGP demonstration sites and the AQC participant groups to drive improvements in clinical quality demonstrates the non-budgetary value of the ACO model. If nothing else, the evidence suggesting improved care quality within shared savings payment structures should be encouraging to observers assessing the promise of the ACO model.

#### *B. Bundled Payments in Medicare Demonstrations & Private-Sector Payments*

As CMS works to advance the bundled payment strategy through both the Bundled Payments for Care Improvement Initiative and the National Pilot Program on Payment Bundling, it will be critical to consider the successes and setbacks of various Medicare demonstrations and private-sector payment initiatives that attempted to implement bundled payments.

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82. *Id.* at 909.

83. *Id.* at 913 (showing AQC quality improvement reflected as an “increase of 2.6 percentage points in the proportion of eligible enrollees for whom quality thresholds for chronic care management were met; and an increase of 0.7 percentage points in the proportion of eligible enrollees for whom pediatric care thresholds were met.”).

84. Song et al., *supra* note 78, at 909.

Identifiable characteristics of successful programs should then be reflected in a National Pilot Program on Payment Bundling. CMS has a wealth of experience in testing early models of bundled payments, specifically through its implementation of (1) the Medicare Acute Care Episode (ACE) Demonstration;<sup>85</sup> and (2) the Medicare Gainsharing Demonstration.<sup>86</sup> Additionally, Geisinger Health System's ProvenCare® payment initiative can serve as a model for bundling of payments across acute and post-acute care settings.<sup>87</sup>

The Medicare ACE Demonstration allowed participating hospital groups to receive a global bundled payment rate for all Medicare Part A and Medicare Part B services for a given medical condition<sup>88</sup> within the scope of

85. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 646, 117 Stat. 2066, 2324-25 (2003) (amends the Social Security Act by adding new section 1866C to authorize the Secretary of HHS to "approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources."); *see also* CTRS. FOR MEDICARE AND MEDICAID SERVS., FACT SHEET, ACUTE CARE EPISODE DEMONSTRATION (2009), <https://www.cms.gov/DemoProjectsEvalRpts/downloads/ACEFactSheet.pdf> (announcing that the Secretary was using demonstration authority under Social Security Act § 1866C to establish the Medicare Acute Care Episode Demonstration).

86. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5007(a), 120 Stat. 4, 34 (2006) ("The Secretary shall establish a qualified gainsharing demonstration program under which the Secretary shall approve demonstration projects . . . to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with sharing of remuneration as specified in the project.").

87. AM. HOSP. ASS'N COMM. ON RESEARCH, BUNDLED PAYMENT: AHA RESEARCH SYNTHESIS REPORT 6-7 (2010), <http://www.hret.org/bundled/resources/BundledPayment.pdf> (noting that resulting increases in provider compliance with best practices, improved 30-day clinical outcomes, and reduced average length of stay and 30-day readmission rates achieved by the Geisinger Health System within its ProvenCare payment model).

88. CTRS. FOR MEDICARE AND MEDICAID SERVS., SOLICITATION FOR APPLICATIONS: ACUTE CARE EPISODE DEMONSTRATION 8-9 (2009), <https://www.cms.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf> (explaining that ACE Demonstration applicants are required to provide bids to establish a "bundled payment rate for each episode of care included in the demonstration at that site," which will cover

cardiovascular procedures and orthopedic procedures.<sup>89</sup> Additionally, in establishing their bundled payment rate bids, Medicare ACE Demonstration participants were required to provide a discount from the “estimated Medicare Part A and Part B payments that would be made in absence of the demonstration.”<sup>90</sup> CMS required that ACE Demonstration-participating sites accept the single bundled payment as payment in full for each episode of care, with the episode of care encompassing the entire hospital stay.<sup>91</sup> This payment structure in some ways reflects Model Four in the Bundled Payments for Care Improvement Initiative in that it focuses on a single prospective payment for all hospital facility services and physician services within prevalent hospital episodes such as coronary bypass and total knee replacement.

Given that the Medicare ACE Demonstration has only been in operation for two years and results are limited, it is helpful to assess the results of a similar predecessor to the ACE Demonstration, the Medicare Participating Heart Bypass Center Demonstration.<sup>92</sup> The Medicare Participating Heart Bypass Center Demonstration tested a payment model consisting of a single bundled payment for inpatient hospital services and physician services associated with coronary artery bypass surgery.<sup>93</sup> This demonstration project yielded impressive results, including a 10% reduction in Medicare spending as compared to Medicare Part A and Part B expenditure levels that would have otherwise been generated under traditional Medicare FFS reimbursement.<sup>94</sup>

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all Medicare Part A and Part B services for a given medical-severity diagnosis related group (MS-DRG) under the Medicare Inpatient Prospective Payment System (IPPS), noting that “these rates shall be specific to each hospital and DRG.”).

89. *Id.* at 6.

90. *Id.* at 8-9.

91. *Id.* at 9.

92. IMPROVING INCENTIVES IN THE MEDICARE PROGRAM, *supra* note 64.

93. JERRY CROMWELL ET AL., HEALTH ECON. RESEARCH, INC., MEDICARE PARTICIPATING HEART BYPASS DEMONSTRATION: FINAL REPORT 5 (1998), [https://www.cms.gov/DemoProjectsEvalRpts/downloads/Medicare\\_Heart\\_Bypass\\_Executive\\_Summary.pdf](https://www.cms.gov/DemoProjectsEvalRpts/downloads/Medicare_Heart_Bypass_Executive_Summary.pdf).

94. *Id.* at 11.

Model Four in the Bundled Payments for Care Improvement Initiative built on the Medicare ACE Demonstration, which in turn built on the Medicare Participating Heart Bypass Center Demonstration.<sup>95</sup> Thus, Model Four seems to hold tremendous promise for reducing Medicare costs associated with inpatient surgery stays. If evidence from previous Medicare bundled payment demonstrations proves determinative, Model Four could succeed in aligning physician and hospital payments, thereby incentivizing physicians to allocate services in a manner that more efficiently ensures that actual Part A and Part B expenditures remain below the bundled payment rate and allow for provider profit margins.

The Medicare Gainsharing Demonstration allowed for providers to enter into “arrangements between a hospital and physician under which the hospital provided for remuneration (gainsharing payments) to physicians . . . that represent solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and the physician to improve overall quality and efficiency.”<sup>96</sup> Essentially, the Medicare Gainsharing Demonstration tested whether allowing physicians to share in profit margin gains generated when hospitals hold Medicare Part A inpatient care costs below capped diagnosis-related group (“DRG”) payment levels (under the Medicare IPPS) would foster partnerships between hospitals and physicians to enhance quality and efficiency of hospital care.<sup>97</sup>

Thus far in the demonstration, two participating hospitals have been able to allocate incentive payments stemming from improved profit margins under the IPPS. However, CMS has determined that the demonstration has maintained budget neutrality but has not achieved actual Medicare savings.<sup>98</sup> It is difficult to assess the potential of Model One in the Bundled Payments for Care Improvement Initiative through the lens of the Medicare Gainsharing Demonstration, since the demonstration was designed with

95. Social Security Act § 1115A(c), 42 U.S.C. § 1315(c)(1)(A) (2006).

96. CTRS. FOR MEDICARE AND MEDICAID SERVS., NOTICE, MEDICARE PROGRAM: SOLICITATION FOR PROPOSALS FROM RURAL HOSPITALS TO PARTICIPATE IN THE MEDICARE HOSPITAL GAINSHARING DEMONSTRATION PROGRAM UNDER SECTION 5007 OF THE DEFICIT REDUCTION ACT (2006), [https://www.cms.gov/DemoProjectsEvalRpts/downloads/DRA5007\\_Federal\\_Register.pdf](https://www.cms.gov/DemoProjectsEvalRpts/downloads/DRA5007_Federal_Register.pdf).

97. *Id.* at 3.

98. CTRS. FOR MEDICARE AND MEDICAID SERVS., MEDICARE GAINSHARING DEMONSTRATION: REPORT TO CONGRESS ON QUALITY IMPROVEMENT AND SAVINGS 10-13 (2011), [https://www.cms.gov/reports/downloads/Buczko\\_Gain\\_Sharing\\_Final\\_Report\\_May\\_2011.pdf](https://www.cms.gov/reports/downloads/Buczko_Gain_Sharing_Final_Report_May_2011.pdf).

budget neutrality, rather than specific Medicare savings, as its goal. However, the gainsharing model seems to be the weakest of the bundled payment class, as it does not tie physician services under Medicare Part B to the bundled payment rate. As a result, the disconnect continues to exist between volume-rewarding Medicare PFS physician reimbursement and service volume-disincentivizing Medicare IPPS hospital payments.

Finally, the Geisinger Health System's ProvenCare® payment program provides for a single, prospective consolidated charge for certain inpatient procedures—coronary artery bypass graft, among others—that includes preoperative care, surgery, and 90 days of follow-up treatment at a Geisinger Health System facility.<sup>99</sup> Since 2006, the ProvenCare® system has yielded improved quality performance and financial savings—including a 45% decrease in hospital readmissions, a 16% reduction in average length of stay, and a 5% reduction in hospital charges.<sup>100</sup> By consolidating hospital and physician service payments into one bundled payment rate, the ProvenCare® payment system mirrors Model Four in the Bundled Payments for Care Improvement Initiative. In addition, the ProvenCare® success in reducing total care costs and lengths of stay is a positive indicator for the success of Model Four payments. It should also be noted that ProvenCare® moves beyond merely bundling hospital and physician payments. Instead, it actually incorporates follow-up post-acute care services into the consolidated payment rate. Given the required inclusion of post-acute care services in the National Pilot Program on Bundling,<sup>101</sup> ProvenCare® results can further serve as an encouraging case study on the potential Medicare savings that can be generated through bundled payments.

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99. DOUGLAS MCCARTHY ET AL., GEISINGER HEALTH SYSTEM: ACHIEVING THE POTENTIAL OF SYSTEM INTEGRATION THROUGH INNOVATION, LEADERSHIP, MEASUREMENT AND INCENTIVES 8 (2009), *available at* <http://www.commonwealthfund.org/Publications/Case-Studies/2009/Jun/Geisinger-Health-System-Achieving-the-Potential-of-System-Integration.aspx>.

100. *Id.*

101. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,985 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

### III. SYNERGY BETWEEN THE ACO MODEL AND BUNDLED PAYMENTS

#### A. *Policy Background Supporting ACO-Bundled Payment Tandem*

Tremendous value should be placed on ensuring the potential for the ACO programs and the National Pilot Program on Payment Bundling to work in tandem, rather than in separation. Observers should resist the temptation to focus on ACO models and bundled payment models in a separate manner and should not view bundled payments as simply an alternative option for clinically integrated provider groups who do not wish to participate in the ACO programs. In recommending an ACO program for Medicare, MedPAC suggested that:

One potential difficulty with a bundling proposal is that physicians will have new incentive to increase low-severity hospitalization. They would profit because the payment amount received would cover a patient with average resource needs, whereas the low-severity patient they admitted would require low time commitments from the physician. The incentive to keep marginal cases out of the hospital would decrease. In contrast, the ACO creates an incentive to reduce unnecessary admissions. Therefore, the ACO may be seen as a necessary counterweight to the effect that bundling would have on the number of admissions.<sup>102</sup>

Equally important, integrating bundled payments for episodes of care into the provider payment structure within the context of ACOs could provide disincentives for physicians to continue to drive up utilization.

Physicians in a one-sided model, or “bonus only” ACO, who are still reimbursed by Medicare through fee-for-service, may find that the potential for increased individual revenues attained via disbursement of ACO shared savings (which, in turn, could be achieved through limiting excess utilization) is outweighed by revenues that could be generated through Medicare PFS reimbursement for growing service volume.<sup>103</sup> While a requirement for ACOs to eventually adopt the two-sided model of risk-sharing may provide appropriate disincentives for physicians to maintain certain levels of volume growth, incorporating bundled payments for particular episodes of care within an expensive service line could provide a manageable solution for ensuring volume containment.

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102. BUNDLED PAYMENTS FOR CARE, *supra* note 52, at 5.

103. Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,984-86.



The implementation of bundled payments may also ease the transition towards ACO formation and the application of the ACO payment model in many settings that may not currently have the clinical and organizational infrastructure in place to attain assignment of the statutory minimum of 5,000 beneficiaries for the MSSP. Researchers suggest that bundled payments can act as a counterbalance to “the emphasis on primary care typical of capitation or shared savings programs.”<sup>104</sup> While the 2010 health reform law intends to create a shift in access and utilization towards primary care services (and away from specialty service utilization),<sup>105</sup> the current system may lack the primary care infrastructure needed to meet increased demands for primary care in the near term. As such, bundled payments offer a legitimate opportunity for the transition to comprehensive payments for coordinated care during the primary care ramp-up.

### B. Statutory Considerations

The extent to which the ACA’s statutory provisions allow for providers to receive incentive payments in both the ACO programs and the National Pilot Program on Payment Bundling is a focal point in determining the prospects for desired synergy between ACO and bundled payment initiatives. Specifically, section 3022 of the ACA prohibits MSSP-enrolled Medicare ACO providers from receiving incentive payments from other “shaved savings” initiatives within Medicare.<sup>106</sup> Additionally, section 3021 of the ACA prohibits the administration and testing of any pilot at CMMI (e.g., the Pioneer ACO Program) that results in increased Medicare expenditures relative to current law.<sup>107</sup> This exclusion, in effect, would likely result in the

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104. Robert E. Mechanic, *Opportunities and Challenges for Episode-Based Payment*, 365 NEW ENG. J. MED. 778 (2011), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1105963>.

105. Social Security Act § 1899(c), 42 U.S.C. § 1395 (2006).

106. Social Security Act § 1899(b)(4) (requiring that a “provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section: (A) A model tested or expanded under section 1115A [i.e. models tested by the CMS Center for Medicare and Medicaid Innovation] that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.”).

107. Social Security Act § 1115A(b)(3)(B) (requiring that “The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has

prohibition of the administration of a CMMI model where the model participants receive duplicative shared savings payments.

CMS stated that because bundled payments within the Bundled Payments for Care Improvement Initiative will in fact be formed as a discount program rather than a shared savings program, participation in both an ACO program and the Bundled Payments for Care Improvement Initiative would not be prohibited by the ACA.<sup>108</sup> Based on this determination by CMS, one could assume that participation in both an ACO program and the National Pilot Program on Payment Bundling would likewise not be prohibited under the ACA. Based on the discount structure inherent in the bundled payment model (the same structure that is developed in the Bundled Payments for Care Improvement Initiative), ACOs that also participate in the bundled payment model could generate savings revenue through two distinct avenues. Because these separate avenues are not overlapping or duplicative, the simultaneously-earned savings revenues would not violate the ACA's prohibition on duplicative shared savings. First, within the context of bundled payments, the provider group would yield positive revenue margins by holding service costs for a particular episode of care below the discounted bundled payment rate. Second, the ACO would yield additional revenue by holding total expenditures (including the discounted bundled payments) below per-beneficiary spending benchmarks. In a sense, entering into a bundled payment arrangement with CMS can be viewed simply as one tactic that ACOs could use in holding down utilization growth to meet shared savings benchmarks under the MSSP.

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begun, that the model is expected to . . . (ii) reduce spending under the applicable title without reducing the quality of care.”).

108. BUNDLED PAYMENTS FOR CARE, *supra* note 52 (stating that “Under the theory that healthcare transformation requires some synergy between new payment methods and care improvement strategies, and the premise that the Bundled Payments for Care Improvement initiative is not a shared savings program with Medicare, CMS encourages entities to participate in the Bundled Payments for Care Improvement initiative and the Medicare Shared Savings Program, the Innovation Center Pioneer ACO and medical home initiatives, and other shared savings initiatives[;]” but noting that “CMS reserves the right to potentially subject these entities to additional requirements, modify program parameters, or ultimately exclude participation in multiple programs, based on a number of factors, including the capacity to avoid counting savings twice in interacting programs and to conduct a valid evaluation of interventions.”).

#### IV. CHALLENGES IN THE PATH FORWARD FOR BOTH THE ACO AND BUNDLED PAYMENT PROGRAMS

While the ACO programs and the National Pilot Program on Payment Bundling carry tremendous potential for improving care and reducing costs, the initiatives are not free of future challenges and unintended consequences. The potential for ACO formation and integration stemming from bundled payment participation may result in an over-concentration of the hospital markets, which would come at the detriment of private payers and consumers covered under private insurance. MedPAC and other researchers have found hospital providers compensate for low Medicare reimbursement rates in two distinct ways, depending on the concentration of the hospital marketplace in the provider's area.<sup>109</sup> Hospitals in markets where hospital competition is extensive compensate for low Medicare reimbursement rates by eliminating inefficiencies and more aggressively seeking to limit labor and supply-chain-cost-growth.<sup>110</sup> Meanwhile, hospitals in heavily concentrated markets with fewer competing providers tend to compensate for low Medicare rates by shifting costs to private payers, via negotiating much higher payment rates from private insurers seeking to include the hospital in its plan's network.<sup>111</sup> To the extent the latter occurs, ACO and bundled payment savings to Medicare through cost-containment could potentially come at the expense of those who maintain private insurance, because private premiums will continue to increase as a result of increasing hospital payment rate requirements for private payers.

While CMS's primary concern in this situation is containing Medicare cost-growth, CMS should strive to ensure that these efforts to do not have a harmful effect on cost containment in the private insurance market and the overall health system. Observers correctly suggest that efforts to promote the formation of ACOs may result in increased hospital marketplace concentration through robust mergers and acquisitions activity as well as provider consolidation.<sup>112</sup>

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109. James Robinson, *Hospitals Respond to Medicare Payment Shortfalls By Both Shifting Costs And Cutting Them, Based On Market Concentration*, 30 HEALTH AFF. 1265, 1271 (2011).

110. *Id.* at 1269.

111. *Id.*

112. *Id.* at 1270.

In an attempt to address this potential adverse scenario, the Federal Trade Commission (“FTC”) and the Department of Justice (“DOJ”) issued joint statements of antitrust enforcement policy in connection with the final rule on the establishment of the MSSP for ACOs.<sup>113</sup> The statement of antitrust enforcement policy establishes an “antitrust safety zone” for ACOs with a combined market share of clinical services provided, within a common service category, of less than 30% within a geographic “Primary Service Area” (“PSA”).<sup>114</sup> A “common service” is defined as a service provided to patients by ACO participants within a PSA where two or more ACOs operate.<sup>115</sup> The statement of antitrust enforcement policy clarifies that ACOs falling within the safety zone will not be challenged on antitrust grounds “absent extraordinary circumstances.”<sup>116</sup> However, ACOs with greater than a 30% share of combined shares of common services within their PSAs will be subject to FTC/DOJ antitrust scrutiny and may seek an expedited voluntary review from the agencies to determine antitrust compliance.<sup>117</sup> Finally, the statement of antitrust enforcement policy explains that FTC and DOJ will apply a “rule of reason analysis” to determine “whether collaboration [of the providers within the ACO] is likely to have anticompetitive effects, and if so, whether the collaboration’s potential procompetitive efficiencies are likely to outweigh those effects.”<sup>118</sup>

## V. CONCLUSION

In enacting the ACA, lawmakers wisely laid the groundwork for delivery system and payment reforms that strive to make the Medicare program more

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113. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026, 67,026-32 (Oct. 28, 2011).

114. *Id.* at 67,028.

115. *Id.*

116. *Id.*

117. *Id.* at 67,029-30.

118. *Id.* at 67,027 (establishing that, in assessing and weighing the anticompetitive effects with potential procompetitive efficiencies, the agencies will the ACO under standards of health care financial and clinical integration that have been articulated in “various policy statements, speeches, business reviews, and advisory opinions” issued and delivered by the agencies in the past).

fiscally sustainable without reducing benefits or limiting patient access. The forerunners in Medicare payment reform, the Medicare Shared Savings Program and the National Pilot Program on Payment Bundling, both hold great promise for changing the trajectory of Medicare spending growth rates. While the predecessors to the ACO model have had mixed results, some evidence suggests that the two-sided model, and its requirement for ACOs to assume risk of financial loss, can provide sufficient incentives for providers to hold down costs. Similarly, bundling payments to hospitals and physicians for care delivered in connection with an inpatient hospital stay can help to finally ensure alignment in Medicare reimbursement that encourages improved efficiency amongst providers.

However, these programs will need to continue to be implemented with flexibility in order to achieve provider “buy-in” to the programs and to allow for provider groups to simultaneously participate in both models. This simultaneous participation in ACO models and bundled payment models is critical in balancing incentives to control expenditure growth at the global Medicare population-based level with incentives to control cost growth per episode of care. Finally, rigorous antitrust reviews of provider relationships stemming from participation in the two models will be necessary to protect against the over-concentration of provider and hospital markets. The future for both models is bright, but their success will be dictated by implementation decisions made by regulators in the coming years.